HANDBOOK for GROUPS

ONTARIO HEALTH INSURANCE PLAN
Toronto 295, Ontario

ONTARIO

HEALTH INSURANCE

HANDBOOK

FOR

GROUPS

IMPORTANT

This Handbook is prepared for the purposes of your convenience only. For accurate reference, recourse must be had to the provisions of the Provincial and Federal Acts and Regulations respecting these matters.

ONTARIO HEALTH INSURANCE PLAN

TORONTO 295, ONTARIO

September 1972

IMPORTANT MESSAGE TO GROUPS

Under the Ontario Health Insurance Plan Act an Regulations, employers have certain mandatory responsibi ities toward making the benefits of the plan available to a eligible employees. Penalties are provided for failure comply with these requirements.

This Handbook is designed as a further help to thos entrusted with carrying out the employer's responsibilitie It gives detailed instructions on handling of specific situa tions, particularly as they relate to regular reports an remittances to the plan. Additional information of a ger eral character is also included.

The person administering the group has a vital respon sibility – not only to the employer but also to fellov employees who depend upon the employer to protect thei entitlement to Ontario Health Insurance benefits.

Thank you for your co-operation and assistance.

ONTARIO HEALTH INSURANCE PLAN

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A WORD ABOUT THE PLAN

Ontario Health Insurance is a comprehensive Government-sponsored plan of health insurance for the people of Ontario. It provides a wide scope of benefits for medical and hospital services, plus additional benefits for the services of certain other health practitioners. Residents of Ontario - regardless of age, state of health or financial means - are entitled to participate. Tourists, transients and visitors to Ontario are not eligible.

PREPAYMENT IS FOR THE INSURED'S PROTECTION

Prepayment of premiums is a basic requirement of any insurance programme. Ontario Health Insurance premiums are payable three months in advance of the Benefit Period covered. This is beneficial to the insured person as it gives him a prepaid "cushion" which could be very valuable if at any time premiums are not paid when due. And this is just the occasion when the need for Health care may arise.

For the convenience of groups, we reproduce below a "prepayment calendar" showing the benefit periods to which premiums are applied.

Premiums payable in	**Cover the benefit period of:**
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

THE ONLY BASIC HEALTH INSURANCE

Ontario Health Insurance is the only basic Health insurance available to residents of Ontario. Residents are not permitted to receive benefits from any private insurer which duplicate, in any way, the services covered by Ontario Health Insurance.

SUPPLEMENTARY INSURANCE

A resident may carry insurance to cover services not included as benefits under Ontario Health Insurance.

Under the Ontario Health Insurance Act and Regulations, however, the total amount of insurance payments for any resident of Ontario from one or more insurers, including Ontario Health Insurance, **must not exceed the total amount charged by the hospital or health practitioner.**

It is unlawful for any resident to receive payment in excess of this amount.

ELIGIBILITY

Every resident of Ontario is eligible to participate in Ontario Health Insurance, either through a Mandatory Group with which he may be connected, a Collector's Group, or on a Non-group basis.

The Single premium covers only the insured person, the Family premium covers husband and wife, and children under the age of 21 years who are unmarried, not employed, and dependent for support upon the insured person. This would also include, an adopted child or one to whom the insured person stands in the position of a parent and for whom he may claim deduction for income tax purposes.

Also eligible as dependents are children aged 21 and over who are financially dependent upon the insured person because of physical or mental infirmity, provided each such child was financially dependent upon that person prior to

the age of 21. The Family premium does not cover dependent fathers, mothers, aunts, uncles, grandparents, etc.

TEMPORARY ABSENCE FROM ONTARIO

Under certain circumstances, a resident may arrange to continue in the plan while living temporarily outside Ontario. Apply to the Plan for details, stating reason for and expected duration of absence.

PLAN REPRESENTATIVES

From time to time, representatives of the Plan call on insured groups.

These representatives are always willing to give information and guidance to those administering the groups, **but they cannot undertake to perform the duties of the group administrator.**

In addition, Group Field Service representatives are empowered under the Act to inspect and examine books, accounts and records of employers for the purpose of obtaining information relative to the Health Insurance Plan.

Penalties are provided for failing to give the representatives access to the required records.

Group Field Service representatives are located in the following Ontario centres: Barrie, Hamilton, Kenora, Kingston, Kitchener, London, Ottawa, Peterborough, St. Catharines, Sudbury, Thunder Bay, Timmins, Toronto and Windsor. The address of each office is listed in the local telephone directory.

POINTS FOR GROUP ADMINISTRATORS

- The Handbook for Groups is designed to make your job easier. Refer to it frequently.

- Detailed instructions on the completion of Forms 102 and 103 are on the back of the duplicate copy of Form 102.

- Except in situations covered by Exemption No. 3 of Form 108, every person who ceases to remit through your group, whether by becoming exempt or leaving the group, must be issued with a Certificate of Payment, Form 104. See Section 6 (d) for special action in the case of strikes or lockouts.

Section 1

GENERAL PRINCIPLES OF GROUP ADMINISTRATION

(1) The employer is required to remit, and authorized to deduct, the applicable Ontario Health Insurance premiums from the earnings of employees who are insured through his group. However, the employer may pay, or contribute to, the employee's premium.

(2) The prime purpose of the monthly group report is to account for any change in premium payments (Single to Family or vice versa) or in the number of insured persons in the group, since the previous report was submitted. Individual changes are detailed on the Group Reconciliation Form (103) and the total changes are summarized on the Group Remittance Summary Form (102).

(3) The "Exception" type of billing is used so that only the **exceptions** – additions, deletions and changes – need be reported. It is not necessary to spend time checking the names of persons in the group whose insurance remains unchanged. As a periodic check on the accuracy of our separate records, each group will from time to time receive a list of persons who, according to Plan records, are insured in the group.

(4) The amount payable each month is the net number of Single and Family units, multiplied by the applicable premium rates – less refunds approved and shown by the Plan on Form 102.

(5) **Group premiums MUST be remitted to the Plan in the month they are due, which is the third month in advance of the Benefit Month. Payment due in January, for example, would provide benefits for the month of April.**

(6) In an employed group, all employees on the payroll more than fourteen days must be reported and, if applicable, the required premiums paid.

(7) Only employees for whom valid Request for Exemption Forms (108) are submitted are exempt from payment of premiums. (See "Exemptions" Section 3.)

(8) All persons in a group must be paid for the same Benefit Period.

(9) Each person entering a group who claims to be insured must provide his Ontario Health Insurance number. Otherwise he must be treated as uninsured.

(10) **Except in situations covered by Exemption No. 3 on Exemption Form 108, every person who ceases to remit premiums through a group for any valid reason must immediately be given a Certificate of Payment Form (104) by the group, showing the date to which his insurance benefits are prepaid. (See Section 6 for special notes regarding temporary stoppages of pay through sickness, layoffs, strikes, lockouts, etc.)**

Section 2

FORMS FOR YOUR ASSISTANCE

Each one of the forms described below has been designed to be of maximum assistance to persons charged with the responsibility of administering Ontario Health Insurance groups.

FORM 102 — GROUP REMITTANCE SUMMARY

This form is the key to the system of "exception" billing employed by the Plan. The group receives the form each month, showing on line 1 the number of persons remitting through the group at the time of the previous return. It also shows any amount that may be deducted from the group's net payment in respect of approved refunds. The remaining entries must be made by the group and will summarize the detailed information on changes, additions and deletions shown on the Group Reconciliation Form (103). In determining the payment due, the group will multiply the net number of Single and Family units by the applicable monthly premium rates.

> CONVENIENT STEP-BY-STEP INSTRUCTIONS ON HOW TO COMPLETE FORMS 102 AND 103 ARE PRINTED ON THE BACK OF THE FORM 102. FOLLOW THESE STEPS AND SAVE TIME.

FORM 103 — GROUP RECONCILIATION

The form on which groups are required to give details of the changes, additions and deletions summarized on the Form 102. Its purpose is to reconcile the number of persons for whom remittances are actually paid with the number for whom the group is billed. All entries listed on the reconciliation must be coded by the group in accordance with the directions on the back of the Form 102.

FORM 104 — CERTIFICATE OF PAYMENT

One of the most vital documents connected with the Health Insurance Plan, the "104" is the key to continuous protection for all persons insured through groups. **Always check names, initials and numbers for accuracy and ensure that the employee understands the correct use and importance of this Certificate.** Except in situations covered by exemption No. 3 of Form 108, every person ceasing to remit through a group must immediately receive a Certificate of Payment from the group, with the top portion fully completed. The employee must complete the lower portion and immediately present it to his new employer for submission to the Plan. If the insurance cannot be transferred to another group (husband's or wife's) he should forward the Certificate to the Plan without delay to arrange continuous coverage on a Non-group basis.

FORM 108 — REQUEST FOR EXEMPTION

This form must be completed in duplicate by persons who are eligible for exemption from payment of premiums. (See "Exemptions" Section 3) The employer will forward the original to the Plan with the current monthly return and keep a copy on file.

FORM 112 — RECORD OF HEALTH INSURANCE NUMBERS

The form on which each group is supplied with a list of **new** insurance numbers issued to persons paying premiums through the group.

FORM 116 — REQUEST FOR REFUND

The form on which groups should claim refund of premiums, paid through the group, which were not legally payable.

HEALTH INSURANCE IDENTIFICATION CARD

Each insured individual and family is provided with an Identification Card bearing their Ontario Health Insurance number. This card is to be presented to the hospital, physician or other health practitioner when insured services are needed. This card should always be readily available for use in emergencies, and the subscriber should always quote his number when communicating with the Plan.

POINTS FOR GROUP ADMINISTRATORS

- You are not required to register:
  a) an employee who does not complete 14 days employment.
  b) a temporary employee whose employment is scheduled to terminate before the first of the third month following date of employment (See Section 3, Exemption 5).
  c) an insured student who plans to return to school after the vacation period during which he is employed (See Section 3, Exemption 9).
  d) an employee who has received approval from the Ontario Health Insurance Plan or a Provincial or Municipal Welfare Office for premium-free coverage based on age — taxable income — or financial need (See Section 3, Exemptions 1, 2 and 3).

- Do not register:
  a) a person who is not a resident of Ontario

  b) a tourist, transient or visitor to Ontario

Section 3

EXEMPTIONS

(a) Who may claim exemption

Persons in the following categories may claim exemption from payment of Ontario Health Insurance premiums through an employer Group:

(1) A new employee who has received approval from the Ontario Health Insurance Plan for premium-free coverage because of age (65 years or over), or because of taxable income.

(2) An employee who is presently a member of your group and **because of age** of employee or spouse, can now apply for premium-free coverage. (Group Administrator must issue Form 104 for employee to complete and submit to the Ontario Health Insurance Plan)

(3) An employee who has received approval from the Ontario Health Insurance Plan or a Provincial or Municipal Welfare Office for premium-free coverage, based on income or financial need. (Group Administrator should arrange deletion from group. Do not issue Form 104.)

(4) A married woman/man who is insured with spouse. (Family premium being remitted elsewhere) NOTE: This exemption may not be claimed if wife remits her premiums on a Pay-Direct basis.

(5) A temporary employee whose employment is **scheduled** to terminate before the first day of the third month following the month of hire.

(6) An employee who is an insured member of another group.

(7) An employee **under the age of 21** who regularly works **fewer than 24 hours a week** and **earns less than $40.00**

a week. (All **three** conditions in this exemption must apply)

(8) A person who is not a resident of Ontario.

(9) A student registered in an institution of learning, **who is an insured person,** and who indicates his intention to return to school as a student at the end of the vacation period during which he is employed.

(b) How to claim exemption

Exemption is claimed by completing a Request for Exemption Form (108) in duplicate, indicating the reason for the exemption.

Do not make an entry on the Group Reconciliation Form (103) for a NEW employee who is exempt.

Persons claiming exemption because they are already insured must quote the applicable health insurance number and, in exemption (6) the name of the group through which premiums are being remitted.

One copy of the Request for Exemption Form (108) is forwarded to the Plan with the regular monthly report and the second copy is retained for the group's files.

If premiums have previously been remitted through the group for the employee now claiming exemption, the appropriate DECREASE (Code "DE") entry must be made on the Group Reconciliation Form (103). (See Section 5C.)

Immediately an employee ceases to be eligible for exemption, the group must begin remitting premiums to the Plan on behalf of that employee. (See Section 4D for correct procedures.)

EXEMPTIONS ARE NOT "ETERNAL"

An employee's valid reason for claiming exemption today from paying OHIP premiums may not apply tomor-

row. Groups are asked, therefore, to check periodically that the employees' exemptions are still valid.

DO YOUR MEMBERS KNOW?

...that they should have their current Ontario Health Insurance Identification Card available at all times to present to the hospital, physician, or other health practitioner when insured services are needed.

Section 4

PERSONS BEGINNING PAYMENTS THROUGH YOUR GROUP

(A) From other insured groups

Each person entering your group from another insured group must present to you a Certificate of Payment Form (104) signed by an authorized person in the previous group. **This form must accompany the Group Reconciliation Form on which the employee is being reported to the Plan.**

I — ***if in insured status***

If the paid-up benefit date shown on the Certificate of Payment has not been passed at the time of hiring, the employee's insurance must be transferred to your group without any break in protection. Appropriate arrears must be remitted to provide continuous coverage.

After entering his Health insurance number, surname, two initials and date of hire on Form 103, enter "TR" in the Code column. Enter the figure '1' under BASIC UNITS "Increases", and under "Arrears" (if any) show the number of additional months' Single or Family premiums you are remitting to make his paid-up **Benefit Month** the same as that for your group.

If Supplementary insurance is involved, the identical entries must be made under SUPPLEMENTARY UNITS "Increase" (and "Arrears" if any). Units must be the same Single or Family for both BASIC and SUPPLEMENTARY. (See Section 8.)

II — ***if paid beyond your group***

If the insured person's premiums are paid beyond the benefit month for which you are currently remitting, remit one month's premium and the Plan will refund any over-

payment directly to the employee. **Form 104, showing member's mailing address, must be attached for each such case reported.** It is also permissible to omit the transfer from your current reconciliation and show it on the next month's return.

III - ***if paid-up date has been passed***

If the employee's paid-up benefit date has been passed when he is hired, record him as NEW. (See Section 4C) His **former Health insurance number should,** however, be entered on Form 103 and will be retained by the employee when insurance again becomes effective.

IV – ***if person cannot produce Form 104***

A person transferring directly from another group who is unable to produce his Certificate of Payment Form (104), should be advised to obtain this Certificate from his former group without delay. If the Form 104 is not available, make every effort to obtain the Health Insurance Number. If the Certificate or number is not produced, he must be treated as uninsured, reported as NEW and serve the required waiting period.

(B) From Non-Group Status

I – ***if personally registered***

Obtain the Health Insurance number and enter the usual details on Form 103. Begin monthly group payments for an effective date of the first day of the third month after month of hire. The Plan will make any premium adjustments directly with the member.

NOTE: The importance of obtaining the Health Insurance Number cannot be over-emphasized as it can be the key to continuous coverage.

II – ***if spouse of Non-Group participant enters your group***

When a woman currently insured as the spouse of a non-group participant becomes employed in a mandatory group, it is preferred that the Family insurance be transferred to her name and premiums be remitted through the group. However, the husband may, if desired, continue to remit the Family premiums on a direct basis and his wife may claim exemption.

A husband insured as the spouse of a woman paying premiums on a direct basis **must** transfer the insurance to his name and remit through the group.

In either case, to transfer the insurance into the group under the spouse's name, enter the employee's name on your current report under Code "TR". Show the employee's initials – not the spouse's. Follow normal procedures for transfers from Non-Group.

(C) Persons who are uninsured

I – ***if not previously insured***

A person entering your group who has not previously been insured must be shown on your Group Reconciliation Form (103) under Code "NEW". If the employee was hired in the current calendar month, remit one month's premium at the appropriate Single or Family rate. If, however, the employee was hired too late during the preceding month to be listed on your previous Reconciliation, remit two months' premiums – one month under "Increases", one month under "Arrears". Protection will become effective on the first day of the third month following the Month of Hire, i.e. a person hired in January will have insurance effective April 1st. ALWAYS ENTER DATE OF HIRE FOR NEW EMPLOYEES.

II – *if previous insurance has lapsed*

A person entering your group whose previous Ontario Health Insurance has expired, or who cannot produce an Ontario Health Insurance number, should be registered as NEW. If the insurance has expired but the insurance number is available, enter the number, deduct one month's premium and report as NEW.

WHENEVER POSSIBLE, VERIFY THE PERSON'S PREVIOUS ONTARIO HEALTH INSURANCE NUMBER FROM AN OFFICIAL FORM AND ENTER IT IN THE LEFT-HAND COLUMN OF THE GROUP RECONCILIATION FORM (103).

III – *if a new resident*

A new resident of Ontario may retain any existing Health Insurance coverage for a period not exceeding three months after he becomes a resident. This enables him to have continuous protection. When he is hired, add him to your group in the same way as any other NEW uninsured employee. See Section 4 (e) for instructions on enrolling Landed Immigrants, returning Canadians, etc.

(D) Employees no longer eligible for exemption through your group

I – *employee's spouse ceases payment*

When the husband of a woman employee ceases to have premiums remitted through his group, he may pay on a direct basis if desired but it is preferred that the insurance be transferred to the wife's name with premiums remitted through her group. To do so, she must present to you the Certificate of Payment Form (104) issued to her husband

on leaving his group. Report on Form 103 as a Transfer Increase, Code "TR". Remit sufficient Family premiums to make the paid-up Benefit Month the same as that for your group.

When the Family premium ceases to be paid by the spouse of one of your employees, this employee is no longer eligible for exemption. Unless otherwise exempt, begin payments for this employee by following the usual transfer-in procedure from group or pay-direct, but be sure to show the initials of the employee concerned – not those of the spouse.

II – ***employee's spouse dies***

When the spouse of one of your employees who has been insured as a dependant dies, the employee obtains a Certificate of Payment Form (104) from the deceased spouse's employer and is transferred, Code "TR", into your group in the usual way. If the deceased was a husband insured on a non-group basis, only the Health Insurance number is required. If there are eligible dependent children, the Family premium is to be paid.

If there are no eligible dependent children, the Single premium becomes effective on the first day of the month following the spouse's death. Report as a Transfer Increase, Code "TR", and remit one month's Single premium. Attach a note providing date of death and the address to which the Plan may refund any overpayment of premiums.

III – ***employee becomes separated or divorced, or spouse leaves Ontario***

When an employee ceases to be eligible for exemption, because of divorce or separation, or the spouse ceases to be a resident of the province, he or she must be reported as a NEW Single or Family Increase. If reported to you by the end of the month following the month in which the event occurred, continuous insurance may be arranged. Other-

wise, insurance will not be effective until the first day of the third month after you are advised. Do not list the spouse's existing Health Insurance number. An Ontario Health Insurance Identification Card will be issued in the employee's name indicating the effective date of the insurance through your group.

IV – ***part-time employee under age 21 becomes regularly employed***

Immediately an employee under age 21 begins to work regularly more than 24 hours a week OR to earn more than $40.00 a week, premiums must be remitted. Report as NEW on your current Group Reconciliation Form (103) (See – student does not return to School – Section 4 (D) VI.)

V – ***"temporary" employee remains more than 3 months***

A person previously granted exemption as a temporary employee who remains in your employ longer than three months, must immediately be registered in the group, unless exempt under another category. To begin payments, if insured, report as a Transfer Increase, Code "TR".

If he or she is not insured, or is insured as a dependent child under a Family certificate, report as NEW and remit premiums retroactive to the month of hiring. Protection will then take effect as of the first day of the third month after date of hiring. IN ALL SUCH CASES A COVERING LETTER SHOULD BE INCLUDED WITH YOUR REPORT.

VI – ***student does not return to school***

Immediately it is determined that an employee (exempted as a student and insured as a dependent child) will not be returning to school, report as NEW on Form 103 for the current month. This will make his personal insurance

effective on the first day of the third month following the month in which his employment becomes permanent.

If he is insured in his own name or as a dependent spouse who now becomes subject to mandatory deductions, report him as a Transfer Increase, Code "TR" on your Group Reconciliation Form (103).

VII – ***employee ceases remitting through another group***

An employee who has ceased to be exempt, because premiums are no longer being submitted in his name through another group, must immediately transfer registration to your group. The Certificate of Payment Form (104) issued to him on leaving the other group should be presented to you without delay.

Report the employee as Code "TR" on your Group Reconciliation and remit sufficient premiums to make the paid-up Benefit Period the same as that for your group. If the employee does not advise you of the change until after the paid-up date shown on his Certificate of Payment, HE MUST BE TREATED AS UNINSURED (See 4C) but be sure to enter his Health Insurance Number.

(E) Landed Immigrants, Returning Canadians

I – ***Landed Immigrants (approved for Landed Immigrant status by Manpower and Immigration)***

Immediate coverage may be arranged for a Landed Immigrant provided the hiring date occurs within 90 days of arrival in Ontario. If immediate coverage is to be arranged, remit sufficient premium arrears to provide a benefit date of the first day of the month following the **month of hire.** An explanatory note should be added to Form 103 on which such persons are reported as NEW.

II – ***returning Canadians or Landed Immigrants (former residents of Canada or previously approved Landed Immigrants who have now returned to reside in Ontario)***

Immediate coverage may be arranged for a returning Canadian or former Landed Immigrant provided the hiring date occurs by the end of the month following the month of arrival in Ontario. If immediate coverage is to be arranged, follow same procedure on Form 103 as in paragraph I above.

(F) Persons entering your group after discharge from:

Royal Canadian Mounted Police, or Regular Canadian Armed Forces

Such persons with one or more eligible dependents will receive a Certificate of Payment Form (104) from the Royal Canadian Mounted Police or their Service Paymaster. Report as a normal Transfer Increase, Code "TR", on your Group Reconciliation Form (103), and remit regular Family premiums for a Benefit Period commencing with the first day of the third month following the month of hire. Any advance payment beyond the paid-up date of the group will be refunded directly to the employee by the Plan.

Single persons **without eligible dependents** do not pay Ontario Health Insurance premiums while serving in the Royal Canadian Mounted Police or Regular Canadian Armed Forces and will not, therefore, be issued with Form 104 on discharge.

Such persons entering your employ by the end of the month following the month of discharge, as verified from the official discharge papers, may, if they wish, obtain immediate protection by paying premium arrears to provide a benefit date of the first day of the month following

discharge. When reporting such cases, you should always add an explanatory note to Form 103. If the employee does NOT wish to take advantage of immediate protection, he should be reported in the same way as any other UNINSURED person and premiums should be remitted to establish an effective date of the first day of the THIRD month following the month of **hiring.**

In either event, the single employee should be reported under Code "NEW" on the Group Reconciliation Form (103).

(G) After discharge from a Provincial psychiatric facility.

If the employee is insured: (a) in his own name; or (b) as a dependent spouse who now becomes subject to mandatory deductions, handle as a normal TRANSFER.

If the employee is insured as a dependent child, or is uninsured, report as NEW, and remit premiums to provide an effective benefit date of the first day of the third month following month of hire.

If the employee is uninsured, follow same procedure as in Section 4 (C) I.

If insurance in his own name has expired, show the former Ontario Health Insurance number on the Group Reconciliation Form (103).

(H) After discharge from:

Canadian Penal or Correctional Inst.

If the employee is uninsured and is hired, or re-hired, by the end of the month following the month of discharge, he may arrange immediate insurance, if desired. In this event, remit sufficient premium arrears to provide a benefit date of the first day of the month following discharge. An explanatory note should be added to the Form 103, on

which he is reported as NEW. If such an employee does NOT wish to take advantage of immediate insurance, premiums should be remitted to establish a benefit date of the first day of the third month following the month of hiring. Report as NEW.

If employee is insured, treat as in Section 4(g).

POINTS FOR GROUP ADMINISTRATORS

- Always enter Date of Hire for new employees.

- Wherever possible, persons whose previous insurance has expired should be re-insured under their former O.H.I.P. number ..... when premiums are resumed. For this reason, the former number should be entered on Form 103 when you are adding such persons to your group.

- The Plan does not require an employer to pay any part of the premium for any employee.

- Should the payment of the Family premium be transferred to either husband or wife it is important that there is no break in the continuity of coverage.

Section 5

PERSONS CEASING PAYMENT THROUGH YOUR GROUP

(a) Form 104 must be issued

Every person ceasing to pay premiums through your group must be issued with a Certificate of Payment Form (104). It is VITAL that this form be completed correctly in every detail. The paid-up date to be entered will be determined by checking the latest benefit month for which premiums were remitted through your group. For example, if your latest premium payment for the employee was made in March and covered the benefit month of June, 1967, the paid-up date should be entered as:

Day	Month	Year
1	7	67

Similarly, if your latest remittance was in April and paid for the benefit month of July, the paid-up date to enter on the Certificate of Payment would be 1-8-67.

When in doubt always refer to the Group Remittance Summary Form (102) accompanying the Group Reconciliation Form (103) on which the employee is reported as having ceased payments through your group. The **Benefit** date entered by the Plan at the top of the 102 Form is the date to be entered by you on the Form 104.

The employee should enter his address in the lower portion of the form and indicate his marital status in the appropriate panels.

THE CERTIFICATE OF PAYMENT FORM (104) IS THE KEY TO CONTINUOUS PROTECTION FOR ALL PERSONS INSURED THROUGH GROUPS. ALWAYS CHECK NAMES, INITIALS AND NUMBERS FOR ACCURACY AND ENSURE THAT THE EMPLOYEE UNDERSTANDS THE CORRECT USE AND IMPORTANCE OF THIS CERTIFICATE.

(b) Termination of employment

Report as Code "LE" (Left Employ) on your Group Reconciliation Form (103). Enter figure '1' in the appropriate "Decrease" column(s).

(c) Employee becomes eligible for exemption

Except in situations covered by exemption number 3 of Form 108, persons remitting premiums through your group who become eligible for exemption **but who continue to be employed by you,** must be issued with a Form 104, showing the date to which insurance is paid-up through your group. Report as Code "DE" (Decrease) on your Group Reconciliation Form (103) and enter the figure '1' in the appropriate Single or Family "Decrease" column(s). A Request for Exemption Form (108), signed and completed by the person claiming exemption, must accompany the Reconciliation.

(d) Employee dies

In the event of the death of a member of your group, a Certificate of Payment Form (104) showing the paid-up benefit date, must be sent immediately to the spouse so that continuous coverage may be arranged. If there is no surviving spouse, send the Certificate of Payment to the deceased person's estate in care of his last-known address.

When reporting to the Plan, show the deceased person's name on your Group Reconciliation Form (103) as a "Decrease", Code "DE". Enter figure '1' in the appropriate Single or Family "Decrease" column(s).

(e) Protection for persons ceasing to reside in Ontario

When a member leaves your group to take up residence outside Ontario, report this to the Plan on your Group Reconciliation Form (103) as a normal Decrease under Code "LE" (Left Employ). Issue a Certificate of Payment Form (104) to the member showing the paid-up benefit date of his insurance.

To assist such persons in arranging continuous insurance in their new place of residence, Ontario Health Insurance benefits may remain effective up to four months after an insured resident takes up residence elsewhere, provided premiums are prepaid for the period. However, benefits cease automatically, when an insured person becomes eligible for similar health insurance protection elsewhere.

Section 6

EMPLOYEES WHOSE WAGES HAVE BEEN STOPPED TEMPORARILY THROUGH SICKNESS, LAY-OFF, W.C.B., ETC.

If premium payments are being suspended on behalf of an employee whose earnings have ceased temporarily, report as a Non-deduct, Code "ND", on your Group Reconciliation Form (103). Enter figure '1' in the appropriate "Decrease" column(s).

IMPORTANT NOTE

Once a person has been reported as a Non-deduct do not list him on your Reconciliation again until his premiums are being resumed through your group. Use of the Code "ND" removes the person from the count of premium-payers for whom you will be billed by the Plan on Form 102. He will not be added to it again until you report that premiums are being resumed. Therefore, if the person never returns to your group, no further entry is required on your Group Reconciliation Form (103). (See paragraph (c) below.)

(a) If stoppage is brief

If a person previously reported as "ND" resumes premium payments through your group before his paid-up Benefit Period expires, list him on your Reconciliation as a Renewal, Code "RE" and enter month of re-hire. Sufficient premium arrears must be remitted to bring the paid-up date back into line with your group.

(b) If stoppage is prolonged

If premium payments have not been resumed by the first day of the final month of the employee's paid-up Benefit Period YOU MUST ISSUE A CERTIFICATE OF PAYMENT FORM (104) IMMEDIATELY. This will permit the employee to arrange continuous coverage pending his return to work. If he does so, and later resumes premiums through your group, he should be listed on the Reconciliation as a normal Transfer Increase, Code "TR", and **not as a Renewal.**

A person resuming employment who has permitted his insurance to expire by the time premium payments are resumed through your group, must be regarded as uninsured. Report as "NEW" on your Group Reconciliation Form (103) and **enter the person's Health Insurance number** in the left-hand column (see Section 4C).

(c) If former "Non-deduct" does not return to group

A person who does not return to your employ after having been removed from your list of premium-payers as a Non-deduct must NOT be reported again on your Group Reconciliation Form (103). (See "IMPORTANT NOTE" at the beginning of this section.)

(d) Strikes or lock-outs

In the event of a strike or lock-out the employer must notify the Plan within four days.

Unless requested by an individual member, Certificate of Payment (Form 104) need not be issued until the first day of the last month of the benefit period for the group.

EMPLOYEES CHANGING INSURED STATUS

All changes in insured status from Single to Family or vice versa must be reported on the Group Reconciliation Form (103) under Code "CH" (Change).

(a) From Single to Family through marriage, etc.

When a person insured at the Single rate through your group marries and is required to pay the Family premium, you must be notified of the fact before the last day of the month following the month of marriage. Except in the case of a person eligible for exemption, sufficient premiums should be remitted at the increased rate (difference between Single and Family) to make Family coverage effective on the first day of the third month following the **marriage.**

A person marrying in June, for example, should notify you by the end of July in order to have Family coverage effective September 1st. If the change is reported in time for inclusion on your **June** Reconciliation, a straightforward "Single Decrease" and "Family Increase" is all that would be required to establish the proper effective date.

If, however, you are not notified of the marriage until after your June return has been prepared, your **July** Reconciliation should show one Family "Increase", one Single "Decrease" and one Single "Arrears".

Similarly, if you are notified of the change too late in July for inclusion in your July report, your August return will be for one Family "Increase", one Single "Decrease" and two Single "Arrears".

In each of the above cases, Family insurance would become effective September 1st.

IF YOU ARE NOT NOTIFIED BY THE END OF THE MONTH FOLLOWING THE MONTH OF MAR-

RIAGE. Family insurance will not become effective until the first day of the third month following the month in which you are notified.

I — ***addition of eligible dependent***

The procedure outlined above also applies in any other circumstances causing a change from Single to Family status.

NOTE: In all cases, persons already insured in the plan will be eligible for continuous protection.

(b) From Family to Single

I — ***sole dependant dies or changes status***

If a change from Family to Single insurance is caused because of the death or changed status of the insured person's **only** eligible dependent, the reduction in premium will become effective on the first day of the month following the event. The Request for Refund Form (116) should be used to request Plan approval to refund the excess premiums paid at the Family rate. The Plan will authorize such credits on your next Group Remittance Summary Form (102).

Report as a "Family Decrease" and "Single Increase" on your Group Reconciliation Form (103).

II — ***divorce or separation***

When the change from Family to Single insurance is caused by divorce or separation, the change to Single status will not become effective until the first day of the THIRD month following advice of the event. Report as a "Family Decrease" and a "Single Increase" on your Group Reconciliation Form (103).

Caution – A male employee who is separated may still be legally responsible for the "necessities of life" for his wife, including Health Insurance.

IMPORTANT

Certificate of Payment Forms received by the group from insured persons as evidence of insured status, must accompany the Group Reconciliation Form on which the employees concerned are being reported to the Plan.

Section 8

ADDING AND DELETING SUPPLEMENTARY INSURANCE

IMPORTANT NOTE

In this Section, Supplementary insurance refers only to the additional hospital coverage provided by a private insurer having an arrangement under which the additional premiums are paid through the Plan. (See also "Supplementary Insurance", page 2).

(a) How to form a Supplementary Group

Arrange with the Supplementary insurer concerned the date on which Supplementary benefits are to become effective for the group. Report each employee who is adding Supplementary insurance as a Change, Code "CH", on the Group Reconciliation Form (103), showing the figure '1' in the appropriate Single or Family Supplementary "Increase" column. Appropriate entries should also be made in the Supplementary "Arrears" column if additional premiums are required to provide the effective date agreed upon between the employer and the Supplementary insurer.

(b) How to add Supplementary Insurance

I — ***for employees already remitting Basic premiums through your group***

Supplementary benefits for employees wishing to join an established Supplementary group will become effective on the date agreed upon between the group and the Supplementary insurer. Report as a Change, Code "CH", on the Group Reconciliation Form (103), showing the figure '1' in the appropriate Single or Family Supplementary "Increase"

column. The appropriate entry should also be made in the Supplementary "Arrears" column if additional premiums are required to provide the agreed effective date.

II – ***for a NEW employee who has Basic insurance only***

If you have an established Supplementary group, a person who adds Supplementary insurance to existing Basic coverage at the time he enters the group, becomes eligible for Supplementary benefits as of the first month for which you are remitting on his behalf. Report him on the Group Reconciliation Form (103) as a normal Transfer, Code "TR". If the new employee's paid-up date is the same as your group paid-up date, remit one month's premium for both Basic and Supplementary insurance.

If arrears must be paid to bring the Basic insurance into line with your group paid-up date, THE SAME NUMBER OF MONTHLY PREMIUMS MUST BE REMITTED FOR SUPPLEMENTARY INSURANCE. In other words, such persons must always have the same effective date in your group for both Basic and Supplementary insurance.

III – ***for a NEW employee who is UNINSURED***

If you have an established Supplementary group, and a NEW employee who is **uninsured** desires both Basic and Supplementary coverage, report on your Group Reconciliation Form (103) under Code "NEW". Enter the figure '1' in the appropriate Basic and Supplementary "Increase" columns. Protection at both levels of insurance will become effective on the first day of the third month following the month of hiring.

IV — *for a NEW employee wishing to continue Supplementary insurance*

Regardless of whether or not you have an established Supplementary group, a person who already has Supplementary insurance when he enters your group, may transfer this coverage if:

(1) The employer is willing to deduct and the insurer is willing to accept the additional premiums; and

(2) only one Supplementary insurer having an arrangement with the Plan is insuring persons in the group.

IN ALL CASES, MARITAL STATUS FOR BOTH BASIC AND SUPPLEMENTARY COVERAGE MUST BE THE SAME. A person cannot have **Family** Basic and **Single** Supplementary insurance, or vice versa.

(c) How to delete Supplementary Insurance for a person remaining in your group

Simply enter the figure '1' in the appropriate Supplementary "Decrease" column and report under Code "CH" on your Group Reconciliation Form (103). Supplementary benefits will cease on the first day of the month covered by your current group remittance.

(d) Continuation of Supplementary Insurance for employees who become eligible for premium-free basic health coverage because of age, taxable income or financial need.

Such persons should contact their Supplementary carrier regarding continuation of Supplementary insurance.

HELP IN PAYING OHIP PREMIUMS

A reduced income, or financial difficulties, need not prevent a resident from having OHIP protection. The Ontario Government has set up a number of ways in which they may obtain help in paying the premiums.

These are:

Premium Assistance

The following assistance is available if the applicant has lived in Ontario for at least twelve months immediately prior to applying for premium assistance:

(a) **Full premium assistance** – If it is estimated that the applicant and his eligible dependents, combined, will have NO TAXABLE INCOME in the current year, they may apply for full premium assistance.

If the application is approved, they will receive OHIP coverage at no cost - the Ontario Government will pay the full premium.

(b) **Partial premium assistance** – The applicant will be required to pay only HALF the regular premiums if he falls into one of the TAXABLE INCOME brackets shown below, and the application is approved:

Single:

If estimated TAXABLE INCOME for the current year will be $1,000 or less:

Applicant pays	**Ontario Government pays**
$66.00 a year ($16.50 every three months)	$66.00 a year

Family:

If applicant and dependent(s) have an estimated combined TAXABLE INCOME of $2,000 or less for the current year:

Applicant pays	Ontario Government pays
$132.00 a year ($33.00 every three months)	$132.00 a year

NOTE: TAXABLE INCOME is NOT the total income during the year. It is the reduced amount of income AFTER taking off exemptions and all other deductions which are permitted.

Temporary Premium Assistance

The purpose of temporary assistance is to provide premium-free Ontario Health Insurance coverage for persons who are temporarily unable to pay the required premiums as a result of unemployment, illness, disability or financial hardship, and who do not qualify for any other form of total premium assistance.

If a resident wishes to apply for temporary premium assistance, he should write to OHIP and request a Temporary Assistance Application form. The amount of financial assistance received will be based on the information provided in that application. Exemption from payment of premiums through your group may be arranged after employee has received approval from the Ontario Health Insurance Plan.

Social Assistance

Premium-free OHIP coverage is available to persons who qualify for assistance through the Ministry of Community and Social Services or through their Municipal Welfare Office.

Section 10

INSURED SERVICES

The following is only a concise description of benefits available under the Plan. More details are available in the OHIP brochure "An Outline of Ontario Health Insurance", available on request.

HOSPITAL CARE

The Plan pays for hospital care which is medically necessary in the treatment of an insured patient in a standard (public) ward of an approved hospital. It also covers a broad range of hospital out-patient services plus medically-prescribed physiotherapy in private non-hospital facilities approved by the Plan.

AMBULANCE SERVICE

Essential and medically-necessary ambulance service is a benefit of the Plan but the insured person is required to pay a small portion of the cost of each trip.

MEDICAL SERVICES

Benefits are provided for medically-necessary physicians' services received at home, in a doctor's office or in hospital. This includes the services of general practitioners and specialists. Payments are made at the rate of 90% of the Ontario Medical Association Schedule of Fees (1971).

OTHER SERVICES

Specified dental surgery performed in hospital is covered up to 90% of the Ontario Dental Association Schedule of Fees (1969) . . . Eye examinations by refraction by an optometrist to determine the need for glasses: $10.00 per person . . . Chiropractic, Osteopathic and Chiropody (Podiatry) services: up to $100.00, plus $25.00 for radiographic examinations, per person, for each of these three types of

services. The dollar maximums quoted above apply to the twelve-month period beginning July 1, each year.

CARE OUTSIDE ONTARIO

Insured physicians' and practitioners' services received outside Ontario are covered to the same extent they would be paid for in Ontario. The amount payable for hospital care is determined by the Plan on the basis of the medical need to obtain the care outside Ontario.

SECTION 11

SERVICES NOT COVERED

- any hospital charges for private or semi-private accommodation;
- hospital visits solely for the administration of drugs;
- charges for care in health spas and other similar facilities;
- charges for dental care normally provided in a dentist's office;
- eyeglasses, artificial limbs, crutches, special braces and other such appliances;
- private duty-nursing fees;
- drugs taken home from the hospital;
- transportation charges other than approved ambulance service;
- medical examinations required for applications for employment or the continuance of employment; life insurance; or admission to camps or recreational activities;
- cosmetic surgery;
- any health service other than those provided by approved hospitals or practitioners as specified in this brochure.

SECTION 12

HOW ARE BILLS PAID?

(a) Hospital Bills

If you receive care in an approved hospital anywhere in Canada, the Plan will make direct payment to the hospital for insured hospital services.

(b) Physicians' Bills

Most Ontario physicians have elected to submit claims for insured services directly to the Plan and to accept the Plan's allowances as full payment.

If a physician has chosen to bill his patients, he will complete a "Pay Subscriber" claim card to be forwarded to the nearest OHIP District Office by his office or by the insured person. In such cases the subscriber will be responsible for any difference between the amount allowed by the Plan and the amount charged by the physician.

(c) Other Practitioners' Bills

Other health practitioners may or may not bill the Plan directly for insured services. In either case the subscriber will be responsible for any difference between the amount allowed by the Plan and the amount charged the by practitioner.

NOTE: See Section 13 (b) regarding claims for physicians' and other practitioners' services received **outside** Ontario.

Section 13

OUT-OF-PROVINCE COVERAGE

If an insured resident has an accident or sudden illness anywhere outside Ontario, the Plan will provide benefits for insured services. However, in most cases, it is necessary for the patient to pay the hospital, physician or other health practitioner and present a receipted itemized bill, along with a medical statement, to the Plan for reimbursement. The following is an outline of the benefits available:

(a) Hospital Services

The Plan pays the full hospital charges (standard ward rate) for medically necessary care in a hospital acceptable to the Plan anywhere in the world EXCEPT where an insured person elects to obtain care in a U.S.A. hospital which could have been received in Ontario. In such cases the Plan pays 75% of the hospital's charges for insured services.

Hospitals in other Canadian provinces bill the Plan directly for insured services provided to Ontario residents.

The Plan will deal directly with any hospital outside Canada which is willing to submit an insured patient's account directly to the Plan. For example, many hospitals in U.S.-Canada border cities and Florida will accept the OHIP certificate just as if you were in Ontario.

(b) Medical, Dental and Other Services

Payment for these services outside Ontario is a direct transaction between the subscriber and the physician or other practitioner. If possible **the subscriber should first check carefully into the cost of such treatment** as the Plan will pay no more for these services than it would have paid if the same services were received in Ontario.

To apply for reimbursement the patient should obtain an itemized account from the physician or other practitioner

and forward it to the nearest OHIP District Office, making sure that all of the following information is included:

1. Physician's Name
2. Subscriber's Surname and Initials
3. Subscriber's OHIP Number
4. Subscriber's Address
5. Patient's First Name
6. Patient's Birth Date
7. Patient's Sex
8. Patient's Relationship to Subscriber
9. Description of Procedure Provided
10. Diagnosis
11. Dates of Services
12. Number of Services
13. Total Fee Charged
14. Hospital Name – if applicable
15. Date of Admission – if applicable
16. Referring Physician's Name - if applicable

NOTE: The subscriber is responsible for the payment of any difference between the out-of-province bill and the amount allowed by the Plan.

Persons planning a trip out of Ontario, should obtain our brochure "Wherever You Go. . . " from a travel agent or any office of the Plan.

Section 14

OTHER PROVINCIAL PLANS

ALBERTA

Health Care Insurance Commission
Box 1360
Edmonton 15

BRITISH COLUMBIA

Medical Services Commission
Parliament Buildings
1410 Government Street Victoria

Dept. of Health Services and Hospital Insurance
Parliament Buildings
Victoria

MANITOBA

Manitoba Health Services Insurance Commission
Dept. of Health and Social Development
Box 925
185 Lombard Avenue
Winnipeg 2

NEW BRUNSWICK

Department of Health
Medicare Division
Centennial Building
Government House
P.O. Box 5100
Fredericton

Hospital Services Division — same address

NEWFOUNDLAND

Health Services Commission
Department of Health
Elizabeth Towers
P.O. Box 200
Elizabeth Avenue
St. John's

NORTHWEST TERRITORIES

Medical Services Plan
302 Corona Building
10645 Jasper Avenue
Edmonton 14

NOVA SCOTIA

Medical Care Insurance Commission
Lord Nelson Building
Halifax

Hospital Services Commission
Department of Public Health
Province House
Halifax

PRINCE EDWARD ISLAND

Hospital and Health Services Commission
Province House
Carlottetown
Royalty Mall, P.O. Box 4500

QUEBEC

Régie de l'Insurance — Maladie du Québec
(Quebec Health Insurance Board)
P.O. Box 6600
Quebec 2

Hospital Insurance Service
Department of Health
(Ministère de la Famille et du Bien-être Social)
Parliament Buildings
Quebec City

SASKATCHEWAN

Medical Care and Hospital Services Insurance Plan
Department of Public Health
Provincial Health Building
3211 Albert Street
Regina

YUKON TERRITORY

Medical Services Insurance
Government Building
Whitehorse, Yukon Territory

Hospital Insurance — same as N.W.T.

Territorial Hospital Insurance
Dept. of Indian Affairs & Northern Development
Territorial Relations Branch
Centennial Tower
400 Laurier Avenue West
Ottawa

Ontario Ministry of Health

Honourable Richard T. Potter, M.D.,
Minister